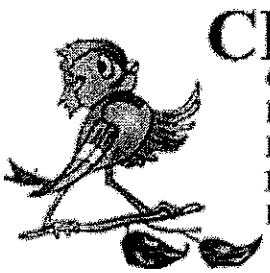

CHIRP
Children and Hoosiers Immunization Registry Program

CHILDREN AND HOOSIER IMMUNIZATION REGISTRY PROGRAM (CHIRP)
RECORD OF PARENT/GUARDIAN OR RECEIPT SIGNATURE

I have read or had explained to me the information in the "Vaccine Information Statement(s)" or the "Important Information Statement(s)" for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions and fully understand the benefits and risks of the vaccine(s) checked below. I request that these vaccines be given to me or to the person name below.

☐ TD ☐ Tdap ☐ MCV4 ☐ Hep A ☐ Hep A/Hep B ☐ MMR

Last Name:	First Name:	Middle Name:	Date of Birth:
Alias Last Name:	Alias First Name:	Patient SSN*:	Age:
Birth State:	Birth Country:	Maiden Name	Gender: M ○ F ○
Race: ○ White ○ African American ○ Asian ○ Multi-racial ○ Other ○ Nat. Hawaiian, Pac Isl. ○ American Indian			Hispanic Origin: ○ Hispanic ○ Non-Hispanic ○ Unknown
Physician Name:	Referring Agency/Employer		
Patient Address			Home Phone: / Work Phone:
City:	State:	Zip:	
Language, if other than English (specify):			Other Phone:
CLINIC USE ONLY	Chart Number:		
Funding Source: ○ Medicaid ○ Uninsured ○ Nat. American or Alaskan ○ Underinsured FQHC Only ○ Hoosier HWise Pkg C ○ Not Eligible			
* Social Security Numbers may be used to identify patients and family members and are optional on this form. There are no penalites for failure to provide SSN.			

Signature of person to receive vaccine(s) or person authorized to consent to the immunization(s)

_____
Signature

_____ _____
Printed Name *Date*

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Technical content reviewed by the Centers for Disease Control and Prevention. October 2011.

www.immunize.org/catg.d/p4065.pdf • Item#P4065 (10/11)